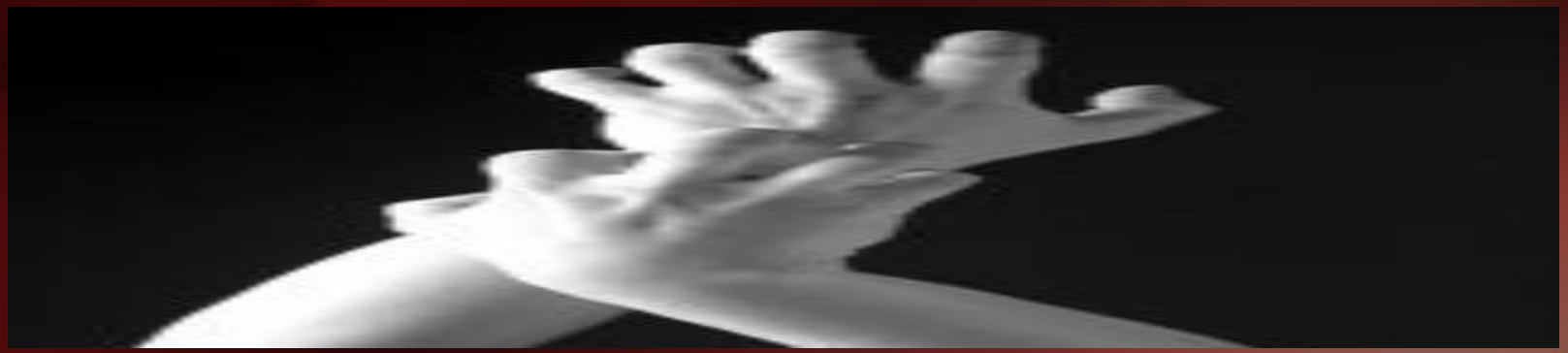


Youth Who Engage in Non-Suicidal Self-Injury—What Does This Mean?

Donald P. Belau, Ph.D.

Dean

Doane Masters of Arts in Counseling

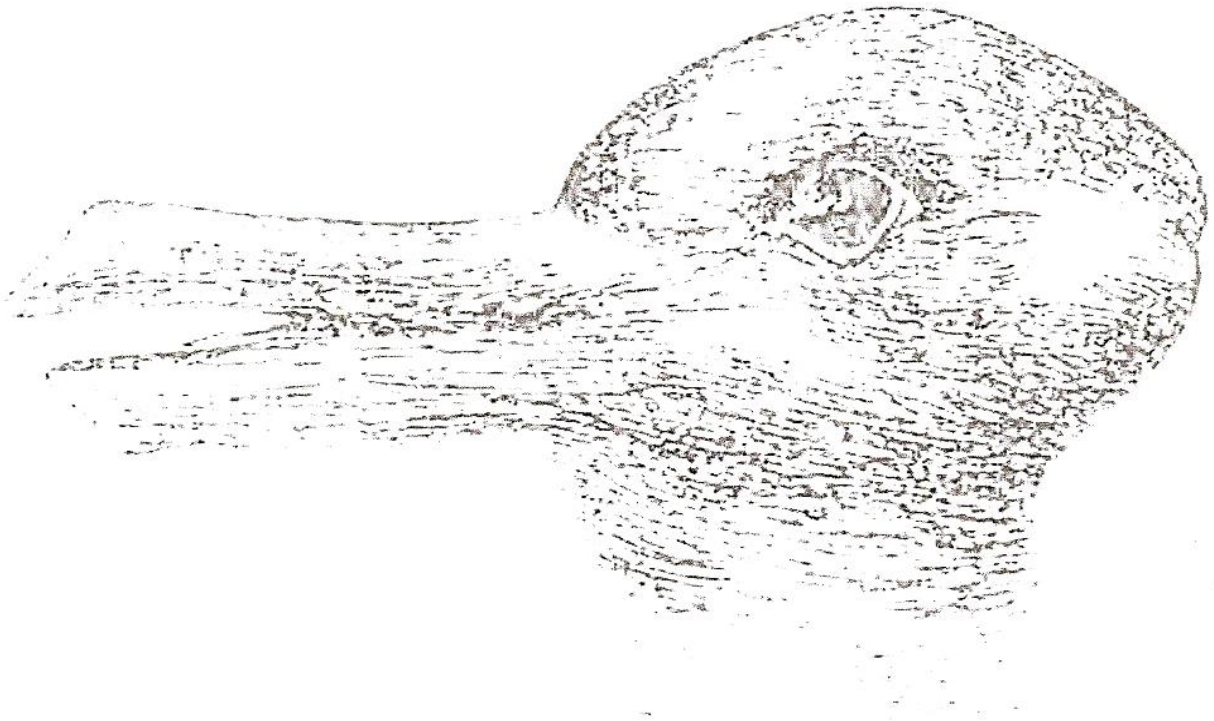
donaldbelau@doane.edu

dbelau72@gmail.com

402-759-0573 cell

Perceptions

- Our perceptions are a reflection of how we react to our environment, our beliefs, and our ability to attend!
- Let's take a peek at the following images, and see how you perceive them.



Perceptioms

- Perceptions are like a crystal
- Multifaceted
- Adults & youth views are refractive, not reflective

Understanding Self-Injurious Thinking of Youth

- Reasons differ, but usually it's to deal with emotional pain.
- I also do it because it makes me forget about everything else.
- Before I feel lost, depressed, and over-whelmed.
- During I forget abut everything and concentrate on the task at hand.
- Afterwards, I feel like a total failure, a freak.

Risk Factors

- Being prone to intense emotional distress with limited abilities to manage it
- Experiencing episodic anxiety or depression
- Spending time in website, message boards, or chat rooms devoted to self-injury

Risk Factors

- Being preoccupied with music, stories, novels about self-injury
- Having performance problems at school, work, athletics, or extracurricular activities
- Having friends who self-injure

Risk Factors

- Experiencing an invalidating environment in which communication is met by erratic, inappropriate or extreme responses
- Painful experience of emotions is disregarded by the environment
- "Snap out of it", "If you don't stop crying, I will give you something to cry about", "I don't want to hear about it"

Risk Factors

- 6 states of mind
  - Intensification of aggressive impulses
  - Narcissism
  - Hypersensitivity
  - Intensified feelings with anxieties about others
  - Turning to action rather than thinking or reflecting
  - Preoccupation with pain

What about Unintentional Self-harm?

What about Unintentional Self-harm?

- Risk-taking behaviors to meet expectations of peers
- "Choking Game" or "Knock-out Game", "Blackout Game"
- Has been around for generations
- New twist
- Use of ligature is resulting in death in unprecedented numbers

Unintentional Self-harm

- Surveys across the country tend to be consistent:
- 11% of all youths aged 12-18 play the choking game
- 19% of youths aged 17-18 play the choking game

Unintentional Self-harm

- Deaths reported in at least 31 states
- Difficult to accurately record
- Appears to sporadic depending upon the media attention/parent surveillance

Choking Game Signs & Symptoms

- Youth makes mention of the choking game
- Bloodshot eyes
- Marks on the neck
- Frequent, severe headaches
- Disorientation after spending time alone
- Ropes, scarves, & belts tied to doors, beds, closet rods, doorknobs, or found knotted on the floor

What about Suicidal Thoughts/Behaviors?

Warning Signs

- Depressed mood
- Substance abuse
- Loss of interest in once pleasurable activities
- Decreased activity levels
- Decreased attention
- Distractibility
- Isolation
- Withdrawing from others
- Sleep/appetite changes
- Morbid ideation
- Writing notes
- Giving possessions away

Warning Signs

- *Verbal cues:*
- I wish I was dead
- No one will miss me
- No one cares
- You won't see me anymore
- You will regret …

- Victim of bullying/peer relationship rejection
- Becoming impulsive
- Sense of self-esteem declining
- Grades declining
- Homework not completed

Warning Signs of Self-harm and/or Suicidal Ideation

- Baggy/inappropriate clothing (e.g. long sleeves in summer)
- Frequent bandages
- Fresh cuts/bruises
- Old scars
- Evidence of rehearsal behaviors
  - Talk of leaving or not being missed

What Is Known:

- Evidence shows that 9 out of 10 teens who have killed themselves will show signals/signs that they are suicidal
- Usually these signs will exist for two weeks or more before a youth will act
- However, some will act out impulsively, particularly if they are under the influence of drugs/alcohol.
- Still others will show no overt signs

Responding to Warning Signs

- Prior suicidal attempts elevate risk to attempt again which calls for elevated monitoring
- Suicide contagion is possible on direct and indirect levels if teen shows a connection

Responding to Warning Signs

- Managing means such as reducing access to firearms, prescription medicine, etc. is critical
- Close monitoring by an adult conveys interest and care—a quality that teens view lacking in the adults around them as a result of their perceptions

Responding to Warning Signs

- Encourage support from key adults such as coaches, teachers, faith-based leaders
- Emphasize positive peer support which is simply showing interest, support, not engaging in put downs
- Promote positive self-worth by acknowledging positive efforts

Responding to Warning Signs

- Encourage connection with positive, caring peers
- Show interest in responsible behaviors
- Encourage positive thinking/perceptions

Responding to Warning Signs

- Ask the tough questions, but with compassion!
- Have you thought about ending your life when you are sad or angry?
- Have you ever physically hurt yourself in any way or have been hurting yourself recently?

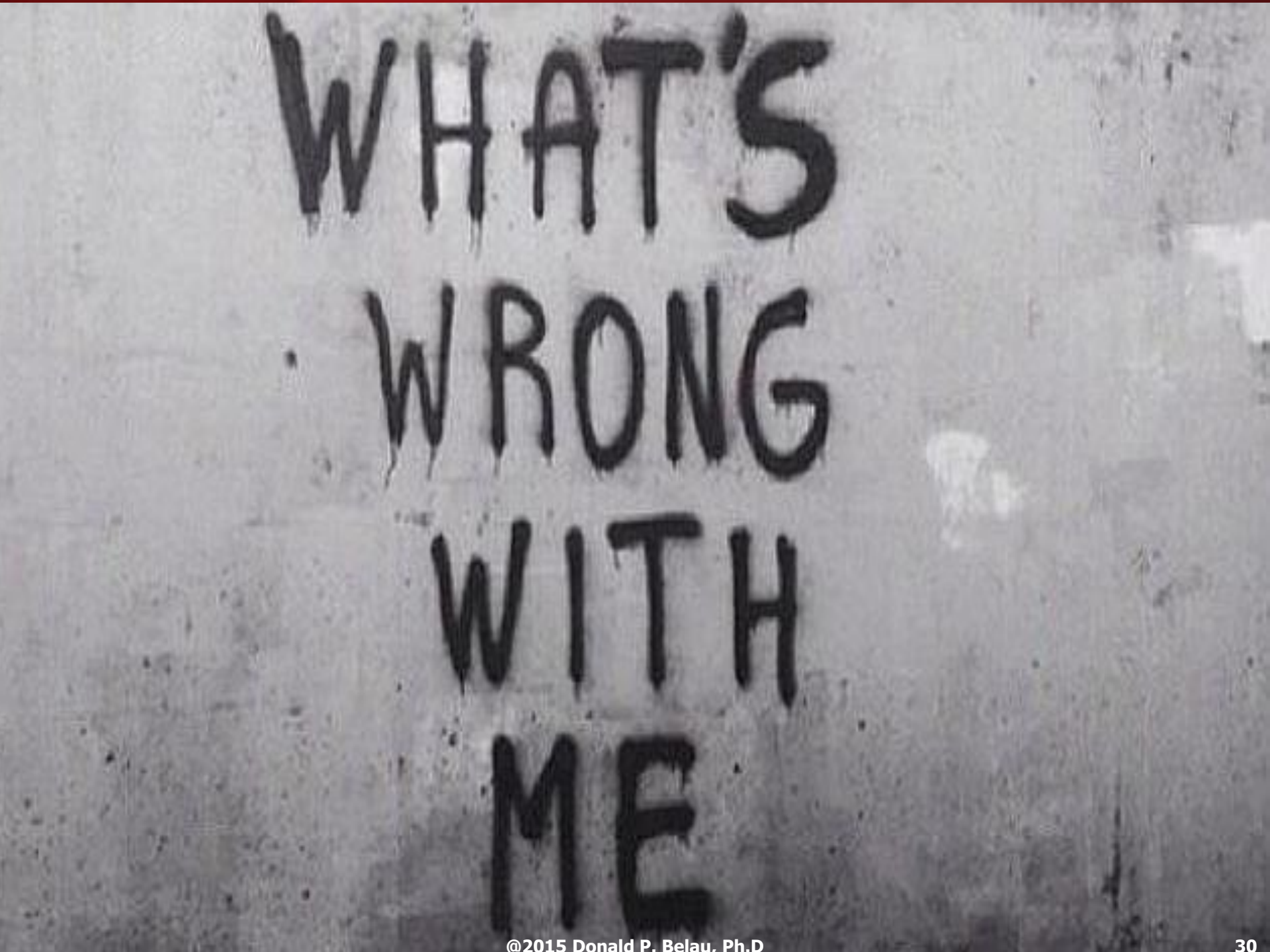
Enhance Protective Factors

- Healthy emotion regulation skills, such as talking with a parent or other trusted adult
- An ability to self-soothe in the face of serious emotional distress

Enhance Protective Factors

- A strong support network
- A positive body image which is inconsistent with self-harm
- Positive thoughts and beliefs that make self-harm inconsistent with one's values

The following slides are disturbing in content, and you may want to prepare yourself, we may be visiting sites that are disturbing as well!!!!




-You're strong. You're beautiful. You're good.
No I'm not.

Definitions

Definition

- **Non-suicidal self injury (NSSI): A form of intentional physical self-damage or self-harm that is not accompanied by suicidal intent or ideation.**
- **The behaviors of NSSI are performed with the expectation that the injury produced will be minor to moderate and will not be life-threatening.**

Definition

- *"Deliberate, repetitive mutilation of the body or a body part, not with the intent to commit suicide but as a way of managing emotions that seem too painful for words to express".*[2]
  - ✓ **Deliberate:** Awareness of harmful effects, intent to cause these effects.
  - ✓ **Repetition:** Act is done with rumination on self-harm evident when individual is not engaging in it.
  - ✓ **Emotional Regulation:** Act allows the person to feel - if they typically don't - or get rid of negative overwhelming emotions and/or racing thoughts.
  - ✓ **Lethal:** While individual may not wish to commit suicide act is possible and often lethal. **Those that self-injure are 30x more likely to attempt suicide and 140x more likely to be successful.**

Types

- **Includes (*in order of frequency*)**
  - ✓ **Scratching or Pinching**
  - ✓ **Banging or Punching objects (#1 in Males)**
  - ✓ **Cutting (#1 in Females)**
  - ✓ **Banging or Punching self (e.g. head)**
  - ✓ **Carving words into skin**
  - ✓ **Ripping or tearing skin**
  - ✓ **Burning self**
  - ✓ **Rubbing sharp objects into skin**
  - ✓ **Trichotillomania**
  - ✓ **Breaking bones**
  - ✓ **Ingesting Substances/Objects**
  - ✓ **Dropping acid onto skin**
  - ✓ **Body mutilation (e.g. genitals)** [5]

Should Self Injury include:

- ✓ Tattoos?
- ✓ Body Piercing?
- ✓ Body Modification?
- ✓ BDSM Behaviors?

Facts

- Exponential growth since 1980's
- Currently considered one of the largest adolescent problems in US/UK[6]
- Average age of onset 14
- Often begins by accident (e.g. cut self shaving)
- Starts out on hands, wrists, arms, then legs, thighs, stomach
- Often done in secret due to personal shame and powerful labels
- Often found in conjunction with other psychological disorders
- May have religious or erotic undertones (e.g. invalidating environment)
- Self-injurers typically do not feel pain or enjoy the pain when they injure themselves
  - ✓ *They hurt themselves not really to inflict pain but, astonishingly enough, to relieve themselves of pain – to soothe themselves and purge their inner demons through a kind of ritual mortification of the flesh."*

Who Self-Injures: Non-Clinical Pop.

- 1-15% of the general public (2-8 million individuals)
- 17% of college population (20%/women; 14%/men)
  - ✓ Highest rates between the ages of 17-24
  - ✓ May serve as a tool to help aid in separation/individuation from enmeshed parents
- Slightly more women (55%) than men (45%)
- Those who experienced Child Abuse or Neglect (50-70%)
- Those who have been sexually abused (54%)
- Those who are bi-sexual or questioning their sexual identity
- Those who grew up in a invalidating environment that lacked sufficient parental support/connectedness
  - ✓ Cold, rejecting mothers
  - ✓ Distant, hypercritical fathers

Who self-injures: Non-clinical cont.

- Those with a history of illness (or a family member who had a serious illness)
- Those from chaotic backgrounds (e.g. foster care, family violence)
- Those who are neurotic and conscientious
- Those who are highly intelligent & creative
- Those who have difficulties with Fear (e.g. prolonged abuse, witnessing violence)
  - ✓Individuals get desensitized, paralyzed or hyper-aroused, hardwired to fear and then need something to help them deal with

Who self-injures: Non-clinical cont.

- Those who demonstrate poor self-care or very low self-esteem
- Those who tend to have patterns of rigid thinking
- Those with low social or interpersonal communication skills
- Those who feel they 'don't fit' or are very lonely
- Those who are very 'body-conscious'
- Those who are emotionally inexpressive

Who self-injures: Clinical Pop.

- Those with an eating disorders (80%)
- Those with a mood disorder (e.g. anxiety and depression)
- Those with Borderline Personality Disorder (BPD) (25-44%)
  - ✓ These patients also engage in splitting (all good/all bad, sadness/anger)
- Those with Dissociative Identity Disorder (DID) (34%)
  - ✓ Scars remain giving the person a type of history
- Those with Substance Abuse issues
- Those with an Impulse Control Disorder
  - ✓ Trichotillomania, Shoplifting, Gambling
- Those with PTSD
- **Three biggest indicators** of self-injurers:
  1. Dissociation
  2. Sense of a loss of control
  3. Psychological numbness/emotional cut-off

Why?

- **Self-injury is first and foremost a coping mechanism**
- **Trauma Re-enactment**
  - ✓ Allows person to be the perpetrator, victim and then care giver
  - ✓ Allows person to inflict punishment that they feel they deserve on themselves vs. others
  - ✓ Many struggle with allowing themselves to become angry
- Allows those whose voices have been silenced to speak another language and express pain
  - ✓ *"There are times when I just hurt too bad, too deep for tears – so I cut and it lets out some of the hurt."* [17]
  - ✓ *"Even if cutters are able to find words to express some of what they are feeling inside, they don't seem to get relief – or at least nothing that compares to the catharsis of cutting."* [18]

Why continued

- Gives people a high that's 'better than sex'
  - ✓ Especially if they cut deeply or hit a major blood vessel
  - ✓ May also lead to loss of consciousness, blood transfusions, accidental death
- May **escape dissociative** experiences using this as a self-grounding technique
- Allows others to share something with others and feel like they belong
  - ✓ Particularly if they have been isolated/distanced from family
- Allows them to have a powerful secret and feel empowered
- Allows the person to **reclaim control** over one's body
- Viewed by many as an **addiction** (follows the addiction cycle)
- Cutting works along the lines of the Law of Diminishing returns (never enough and must cut deeper, longer, more etc. the next time)

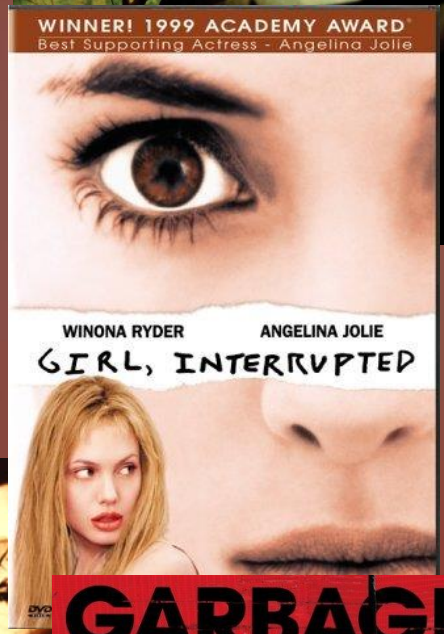
Why continued

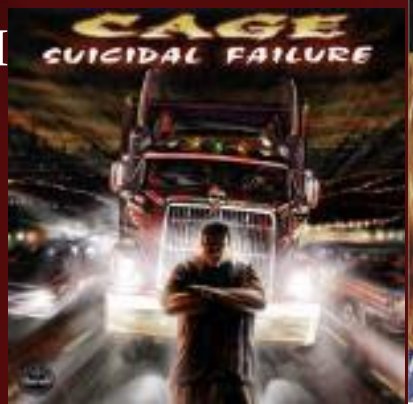
- **Allows many to 'feel something'**
  - ✓ Many are emotionally very cut off, 'emotionally dead'
- **Allows some to 'feel alive'**
  - ✓ Blood is very real, carries life
  - ✓ Skin is how we have contact with the outside world
  - ✓ Experience a pleasure response to the warmth of the blood
- Allows people to drain off anxiety, fear, guilt, shame, aggression or building tension so they won't 'explode'
- Belief that cutting will purge their system of 'bad feelings' etc., makes them feel clean and pure

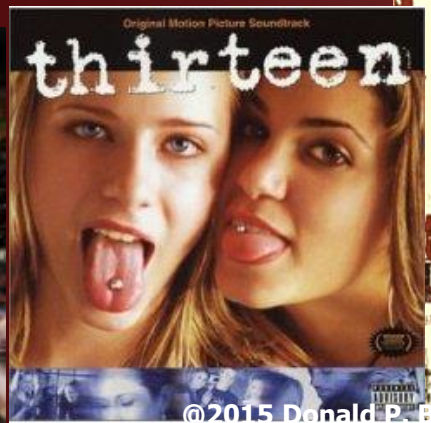
"Serving a variety of purposes for these abused kids, a cry for help, an outlet for pent-up rage, a means of self-punishment, a controllable method of reducing emotional trauma, a form of 'body stimulation' for children who had become inured to pain as a result of physical and sexual trauma, and a way of feeling something other than despair." [19]

Why Now?

- ✓ Adolescents have fewer coping skills
- ✓ Adolescents are influenced by models in their lives
- ✓ Social media such as **Tumblr**
- ✓ Contagion theory (little consensus)
- ✓ More awareness and discussion
- ✓ Increased social stressors
- ✓ Media Influence (e.g. music, movies, Internet etc.)
- ✓ Family Stress/dysfunction/relationship/abuse
- ✓ Greater social acceptance (e.g. tattoos, piercings etc.)
- ✓ Increased isolation
- ✓ I







Effects of the Internet/Social Media

Social Media Sources

- *scarsspeak.tumblr.com/*
- *http://www.tumblr.com/tagged/slit-wrists*
- **http://www.reddit.com/r/selfharmpics**
- **Tumblr, Instagram, and Twitter**

Effects of the Internet

- 10 of 400 Self-injury message boards with over 90,000 active users:
  - ✓Informal support (28.3%),
  - ✓Motivation for self-injury (19.5%),
  - ✓**Concealment of SIB** (e.g., anxiety about exposure, methods for concealment of cuts/scars) (9.1%),
  - ✓Addiction language (e.g., days self-injury free, difficulty stopping) (8.9%),
  - ✓Formal help seeking/treatment (7.1%),

Effects of the Internet

- ✓**Sharing techniques** (6.2%),
- ✓Links to other mental health/behavioral conditions associated with SIB (4.7%),
- ✓References to popular culture (4.2%),
- ✓Perceptions of non-self-injurers reactions to SIB (2.6%),
- ✓Perception of self and behavior (e.g., self-worth, lovability, dissociation) (2.1%), and
- ✓Venting or apologizing (8.6%) [21]

Effects

- **Social networks and internet companies are facing mounting pressure to prevent a surge in self-harm fuelled by graphic images and even DIY style advice online.**

Effects

- **Images of bloodied limbs with open wounds and lacerated torsos which would not look out of place in a war zone are readily available in a disturbing trend triggering some young people to self-harm.**

Effects

- Young people who have harmed themselves to cope with mental distress have told how the internet spurred them on.
- One accused tumblr of being "a feeding-ground for self-harmers who wish to trigger themselves and become indulged in the addiction".

Effects

- "Photos are a very bad idea too it makes self-harming a competition you almost want to be the one who cuts the most."
- But others, like Michelle, claim that pictures help "ride out the urge to self harm" as "it helps to see others with the same cuts, burns and scars as I have, even if they're not people I know.
- It makes me feel less alone".

Effects

- Tumblr, Instagram and Twitter, have become popular places for people to post photos of cutting.
- The hashtag #suicide has 4 million posts on Instagram and there are other more obscure tags such as #selfharmmm, #blades and #selfhate that people use to post disturbing photos of wounds created by self-harm and emotional messages about suicidal thoughts.

Effects

- Other terms such as #secretsociety123, #sue and #ana reveal a collection of posts about being skinny, mingled with those about feeling lonely or wanting to die.

Current Research—summaries of various studies completed by Dr. Jennifer Mulkekamp, Dr. Barent Walsh, Dr. David Klonsky, etc.

References available upon request.

Table 2

Characteristics of Self-Injurious Thoughts

Variable	Suicidal thoughts (%)	NSSI thoughts (NSSI = No; %)	NSSI thoughts (NSSI = Yes; %)
Severity			
Not present (0)	3.8	1.7	0.0
Mild (1)	30.8	25.2	1.0
Moderate (2)	53.8	38.5	18.4
Severe (3)	7.7	25.2	32.0
Very severe (4)	3.8	9.4	48.5
Duration			
<5 s	0.0	5.0	16.5
5–60 s	11.5	20.8	20.4
1–30 min	46.2	39.2	40.8
30–60 min	15.4	19.6	13.6
1–5 hr	15.4	12.5	7.8
>5 hr	11.5	2.9	1.0

Note. NSSI = nonsuicidal self-injury; NSSI = No signifies that participants had NSSI thoughts but did not engage in NSSI behavior; NSSI = Yes signifies that participants reported both having NSSI thoughts and engaging in the behavior.

Table 3
Co-Occurrence of Self-Injurious Thoughts With Thoughts of Other Self-Destructive Behaviors

Variable	Descriptive analyses			HLM analyses: Model 6	
	Suicidal thoughts (%)	NSSI thoughts (NSSI = No; %)	NSSI thoughts (NSSI = Yes; %)	γ	*SE* (γ)
Level 1 predictor					
Intercept	—	—	—	2.24	−2.06
Drug use thought	34.6	20.8	18.3	0.32	0.33
Alcohol use thought	19.2	16.7	13.5	−0.59	0.42
Binge thought	19.2	15.4	16.3	0.89	0.53
Purge thought	7.7	15.8	12.5	−0.40	0.49
Unsafe sex thought	7.7	7.1	4.8	0.12	0.56
Impulsive spend thought	3.8	5.8	4.8	0.05	0.61
Suicidal thought	—	4.2	1.0	−0.69	1.06
NSSI thought	42.3	—	—	—	—
Level 2 predictor					
Age	—	—	—	−0.10	0.10
Gender	—	—	—	−0.87	0.54
Variance component					
$\tau_{00}^{(2)}$	—	—	—	0.61	0.35

Note. NSSI = nonsuicidal self-injury.

Variable	Descriptive analyses: Suicidal thoughts (%)	Descriptive analyses: NSSI thoughts (NSSI = No; %)	Descriptive analyses: NSSI thoughts (NSSI = Yes; %)	HLM analyses: Model 7 γ	HLM analyses: Model 7 *SE* (γ)
"What were you doing?"					
Level 1 predictor					
Intercept	—	—	—	0.95	1.59
Socializing	34.6	31.3	21.2	−0.49	0.50
Resting	19.2	22.9	20.2	0.00	0.43
Listening to music	30.8	13.8	17.3	−0.01	0.69
Doing homework	7.7	12.1	19.2	0.69	0.37
TV/Video games	7.7	13.3	14.4	−0.01	0.46
Recreational activities	3.8	10.8	15.4	0.29	0.43
Eating	7.7	11.3	13.5	0.39	0.47
Using drugs	3.8	2.9	4.8	0.89	0.87
Drinking alcohol	0.0	2.5	3.8	0.22	1.57
Level 2 predictor					
Age	—	—	—	−0.05	0.08
Gender	—	—	—	−0.63	0.58
Variance component					
$\tau_{00}^{(2)}$	—	—	—	0.27	0.31
				HLM analyses: Model 8	
"Who were you with?"				γ	*SE* (γ)
Level 1 predictor					
Intercept	—	—	—	0.72	1.90
Alone	42.3	38.3	49.0	0.79*	0.37
Peer/other	34.6	29.6	16.3	0.15	0.32
Friend	15.4	12.9	16.3	0.71	0.41
Mother	15.4	11.7	9.6	−0.88	0.65
Father	3.8	6.7	5.8	0.61	1.03
Stranger	3.8	5.8	5.8	0.52	0.42
Sibling	7.7	2.9	3.8	1.02	0.89
Other relative	0.0	0.8	1.9	2.10	1.21
Level 2 predictor					
Age	—	—	—	−0.09	0.10
Gender	—	—	—	−0.38	0.51
Variance component					
$\tau_{00}^{(2)}$	—	—	—	0.61	0.37

Table 6
Alternative Behaviors to Self-Injurious Behaviors

Behavior	Suicidal thoughts (%)	NSSI thoughts (%)
Changed thoughts	26.9	22.3
Talked to someone	34.6	20.7
Went out	15.4	18.2
Work/homework	23.1	15.3
Used computer	11.5	14.0
Listen to music	11.5	11.2
Went to sleep	15.4	9.9
Watched TV/movie	3.8	8.3

Note. NSSI = nonsuicidal self-injury.

Table 1

Relation of Nonsuicidal Self-Injury (NSSI) and Other Suicide Risk Factors to Lifetime Attempted Suicide in Four Samples

	Adolescent psychiatric patients (n = 139)	Adolescent community sample (n = 426)	University undergraduates (n = 1,351)	Random-digit dialing United States adults (n = 438)
Predictor				
Suicide ideation	.55	.51	.44	.36
NSSI	.50	.38	.28	.34
Depression	.20	.24	.24	n/a
Anxiety	.16	.18	.16	n/a
Impulsivity	.11	.11	.10	n/a
Borderline personality	.37	.29	.22	n/a

Note. Point-biserial correlations are presented for dimensional predictors of attempted suicide, and phi coefficients are presented for dichotomous predictors. All effect sizes reported are statistically significant at $p < .05$ except for the .11 (Impulsivity) in the adolescent psychiatric sample.

Table 2

Relation of Nonsuicidal Self-Injury (NSSI) to Attempted Suicide for Females vs. Males

	Adolescent psychiatric patients (n = 139)	Adolescent high school students (n = 426)	University undergraduates (n = 1,351)	Random-digit dialing United States adults (n = 438)	*Median Phi*
Gender					
Female	.52	.46	.26	.38	.42
Male	.35	.22	.29	.28	.29
p*	.25	.007	.55	.23	

* p-value indicates statistical significance for the difference between phi coefficients for females vs. males

Table 1. Self-reported age, gender and usage of self-harm and suicide websites

Participant	Age	Gender	Duration of usage	Frequency of usage
1	30	Female	2 to 3 months	Weekly to daily
2	18	Female	6 months	Daily
3	25	Female	3 years	Daily
4	18	Female	6 months	Daily
5	24	Male	2 years	Daily
6	23	Female	1 year	Daily
7	20	Female	6 months	3 times per week
8	33	Female	3 years	Daily
9	21	Female	1 year	Daily
10	18	Female	2 years	Daily

Table 4. Examples of coping

"Since using the boards to tell people how I felt and stuff I definitely think the frequency of my s/h has decreased a lot. I know that if I feel I need to do it I can go on the boards or on msn and someone will be there who I can talk to, and get my feelings out as well as being a way to distract myself." (Participant 7)
"I believe that the way I cope with my depression and sh has changed since I began to use the sites. Although it hasn't eased the symptoms themselves . . . that is I am still depressed and still sh and still have sui thoughts . . . the way I deal with those emotions and actions has changed." (Participant 4)

Self-Injury Data of the NSSI Group (Past Year)

Injury type	Endorsing (%)	Times injured	
		M (*SD*)	Range[a]
Cut	62.5	5.86 (5.50)	2–15
Hit	37.5	6.43 (5.44)	1–15
Burn	25	5.00 (4.36)	2–10
Scrape	25	8.75 (9.00)	1–20
Insert	18.8	11.5 (12.02)	3–20
Tattoo	12.5	3.00 (2.00)	1–5

Note. All participants did at least one of the following: cutting, burning, or scraping. Participants reported first engaging in NSSI an average of 5.87 (*SD* = 4.03) years ago. NSSI = nonsuicidal self-injury; Cut = cutting the skin; Hit = hitting the self (resulting in bruising or tissue damage); Burn = burning the skin; Scrape = scraping the skin; Insert = inserting objects under the fingernails/skin; Tattoo = giving oneself a tattoo.

[a] Minimum–maximum

TABLE 1
Descriptive Features of NSSI

Methods	% (*n*)	NSSI frequency	% (*n*)
Cutting	47.5 (87)	Once	13.6 (24)
Carving	13.7 (25)	2–3	26.0 (46)
Scratch until bleeding	41.5 (76)	4–5	19.2 (34)
Burning	9.3 (17)	6–10	13.6 (24)
Self-Battery to point bruised or bleeding	50.2 (92)	21–50	7.9 (14)
Prevent wounds from healing	11.5 (21)	50 or more	6.8 (12)
Bite self until bleeding/ bruising	12.0 (22)		
Ripped/tore skin	8.2 (15)		
Choking game	3.8 (7)		
Salt/ice burns	2.7 (5)		
Rubbed glass/ inserted sharp object	13.1 (24)		
Other[a]	24.6 (45)		

Note. Participants reported the use of multiple methods so percentages will exceed 100%.

[a]"Other" included behaviors participants wrote in such as pulling out hair, intentionally fighting to be harmed, trying to break bones.

TABLE 2

Initial Motivations and Functions of Repeated NSSI

Initial motivations	% (*n*)	Repeated NSSI functions	% (*n*)
Angry at myself	39.9 (73)	Cope with uncomfortable feelings	43.2 (79)
Upset and decided to try it	36.6 (67)	Relieve stress or pressure	39.9 (73)
Angry at someone else	*22.4 (41)*	Change emotional to physical pain	38.3 (70)
It felt good	16.4 (30)	Deal with frustration	33.9 (62)
Accidentally discovered it	14.8 (27)	Deal with Anger	27.3 (50)
Wanted someone to notice me or my injuries	*10.9 (20)*	To feel something	23.5 (43)
I was drunk/high	7.1 (13)	Distract from problems or task	19.1 (35)
Wanted to fit in with others	*5.9 (11)*	Get control over self or life	15.8 (29)
Wanted to shock/hurt someone	*4.9 (9)*	Self-punish	14.8 (27)
Friend suggested it	*2.7 (5)*	*Hope others notice something is wrong*	*13.1 (24)*
Saw it on TV/Read in Magazine	*1.1 (2)*	Because it feels good	12.0 (22)
"Other Reason"	13.1 (24)	Can't stop the urge	11.5 (21)
I can't remember	15.8 (28)	Because of self-hatred	10.9 (20)
		To help me cry	10.4 (19)
		To shock or hurt someone	*6.6 (12)*
		Because my friends do it	*4.3 (8)*
		To be part of a group	*1.6 (3)*

Note. Social motivations and functions are italicized. Participants reported multiple motivations and functions.

TABLE 3

Group Differences in Social Support between NSSI Groups and Controls

Variable	(1) No-NSSI Mean (*SD*)	(2) Single NSSI Mean (*SD*)	(3) Repeat NSSI Mean (*SD*)	*F*	η^2	Group differences
Total perceived social support	29.75 (4.37)	28.88 (5.18)	25.72 (5.22)	**57.50**	**.09**	3 < 1; 3 < 2
Family perceived social support	15.35 (3.81)	14.50 (4.68)	12.00 (4.49)	**50.77**	**.08**	3 < 1; 3 < 2
Friend perceived social support	14.39 (1.50)	14.38 (1.66)	13.71 (1.85)	**15.45**	**.03**	3 < 1
Total number seek advice from[a]	4.46 (2.62)	3.79 (2.80)	2.92 (2.19)	**29.69**	**.05**	3 < 1
Number peers seek advice from[b]	2.34 (1.24)	2.04 (1.37)	1.66 (1.20)	**27.45**	**.05**	3 < 1
Number family seek advice from[c]	1.50 (1.05)	1.08 (1.28)	0.78 (0.96)	**37.99**	**.06**	3 < 1
Number professionals seek advice from[d]	0.61 (1.28)	0.63 (0.97)	0.46 (0.98)	1.00	.00	—

Significant differences at $p < .001$ are in bold.

[a]Scale ranges from 0–22.

[b]Scale ranges from 0–6.

[c]Scale ranges from 0–3.

Table 2. Evaluating Risk for Self-Injury: STOPS FIRE Assessment Guide

What to Assess	How to Assess It	High-Risk Indicators Warranting Referral for Behavioral Health Services
Suicidal ideations	• "[Specific behavior] might be different than trying to kill yourself, but for some people they're related. Do you ever think about killing yourself when you [specific behavior]? • Do you think about killing yourself when you don't [specific behavior]?"	• Intense thoughts about suicide while self-injurin • Thoughts about suicide before or after self-injuring
Types	• "What have you used to [specific behavior]?" • "In what ways do you injure yourself?"	• Multiple types • ≥3 methods
Onset	• "When did you first [specific behavior]?"	• Early/childhood onset • Extended duration or history ≥6 months
Place/location	• "What parts of your body have you [specific behavior]?"	• Genitals or breasts • Face
Severity of damage	• "Has [specific behavior] ever caused any bleeding/bruising/scarring?" • "Have you ever had to go to the hospital after you [specific behavior]?" • "How do you handle the wound after you [specific behavior]?	• Hospitalization or suturing required • Neglect of wounds • Reopening of wounds
Functions	• "What does [specific behavior] do for you?" • "How do you usually feel before [specific behavior]?" • "How do you usually feel after [specific behavior]?" • "Would it help you in any way if you stopped [specific behavior]?"	• Any relationship to suicide (eg, compromise between living and dying; reduces suicidal thoughts or urges)
Intensity of self-injury urges	• "How strongly would you rate your urges to [specific behavior] in a typical day from 0 to 100?"	• 70 or higher
Repetition	• "About how many times would you say you [specific behavior] since you started?"	• 11–50 (moderate risk) • ≥50 (high risk)
Episodic frequency	• "How often do you [specific behavior] in a typical day? What about a typi[illegible]"	• Multiple times per week • ≥5 wounds per episode

Table 3. Summary of Published Self-Injury Interventions and Respective Levels of Evidence

Intervention	Level of Evidence	SORT Rating	RCTs	Treatment Description	Patients Treated in Published Reports or RCTs (n)	Effect on Self-Injury
Topiramate	3	C	N/A	200 mg/day	3	Cessation of self-injury
Clozapine	3	C	N/A	300 to 550 mg/day for 4 to 12 months	8	Cessation of self-injury
Naltrexone	3	C	N/A	50 mg/day	8	Cessation of self-injury
Dialectical behavior therapy	1	B	3	12-month outpatient program; weekly individual modified cognitive-behavioral therapy; weekly skills training; ongoing skills coaching between sessions	188	Significant reduction of self-injury in 2/3 RCTs compared with TAU group
Manual-assisted cognitive behavior therapy	3	C	2	2–7 individual cognitive therapy-oriented sessions; 70-page self-help book	512	No effect on self-injury
Transference-focused psychotherapy	2	C	2	12-month outpatient program; weekly individual psychodynamic therapy	23	No effect on self-injury
Mentalization-based therapy	2	C	0	18-month inpatient program; weekly individual psychodynamic therapy; weekly group psychodynamic therapy (3×); weekly individual psychodrama session	19	Significantly lower proportion of self-injurers compared with TAU group

The number of patients is from randomized controlled trials only when available or from available, published, nonrandomized studies if no randomized controlled trials have been conducted. SORT, strength of recommendation taxonomy; RCTs, randomized placebo-controlled trials; TAU, treatment as usual.

Social Media: Digital Self-Harm – A Cry for Help

Digital Self-Harm.

- Don’t be surprised if you’ve never heard this phrase before!
- It’s a recently identified condition.
- It’s not a particularly widespread phenomenon but one, nevertheless, that is serious and worth understanding.

Digital Self-Harm.

- Online cruelty, put-downs, and threats are the arena for cyber-bullying.
- We have heard horror stories of kids who have been mercilessly bullied via social media and of tragedies when some kids have chosen to end their own lives as a result.

Digital Self-Harm.

- Media outlets often flock to these types of stories and it's not uncommon for these to attack technology as the culprit.
- But what if it actually turns out that the teen is the originator of her or his cyber-bullying?
- This is what is known as Digital Self-Harm.

Digital Self-Harm.

- But *why* would a teenager engage in digital self-harm?
- Given the recent identification of the behavior, more research is needed to accurately determine the motivation behind digital self-harm.

Digital Self-Harm.

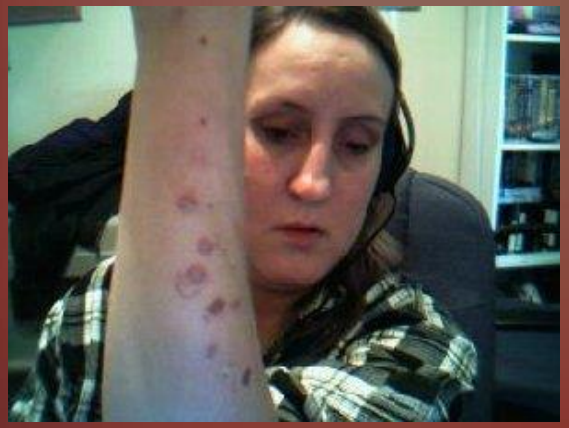
- Yet it seems reasonable to surmise that digital self-harm is at least somewhat akin to physical self-harm:
  - A means to respond to the emotional pain a teen is suffering in his or her life and often — a cry for help.

Digital Self-Harm.

- **Teens might digitally self-harm… as an expression of one's poor self-image.**
  - **as a means to assess how others' view her or him.**
  - **as a means to assess whether peers will defend her or him when cruel or threatening posts appear.**

A Hard Habit to Break - Reinforcers

- Very powerful coping mechanism
  - ✓ Helps with feelings of alienation
  - ✓ Gives voice to feelings
  - ✓ Anchors individual in reality
- Gives a false perception of safety and security
- Allows for expression (or repression) of sexuality
- Repetition Compulsion
- Biochemical relief
  - ✓ Endorphins released for pain management
- False sense of control over self and others
  - ✓ A passive way of getting others to show concern



"Cutting is one of the hardest things to quit and the easiest to go back to" – SweetInnocense90

Cognitive Distortions

- Self Injury doesn't hurt anyone
- I don't understand why it upsets others
- Giving up the behavior will make me hurt more
- The scars remind me of the battle
- It's the best way for others to see my pain
- No one knows that I do it

Cognitive Distortions

- It keeps people away (it keeps me safe)
- It's the only way I know people care
- Negative attention is better than none
- I need to be punished – I'm bad
- It's not my fault, it just happens
- I'm stronger because I can take the pain
- It's better than killing myself [23]

Assessment Strategies

Assessment Strategies

- Incorporate self-injury question into initial assessment
  - ✓ ***Have you ever physically hurt yourself in any way?***
- Inquire about frequency, duration and onset of behavior
- Assess for suicidal ideation, plan and intent
- Explore any recent life experiences, past traumas, current stressors
- Consider any possible medication complications secondary to behavior (infections, objects under skin etc.), seek medical attention if necessary
- Rule out socio-cultural and religious variables
- **Look for**
  - ✓ Depression
  - ✓ Low self-esteem
  - ✓ Inability to express self
  - ✓ High levels of privacy, secrecy
  - ✓ Paraphernalia (e.g. razor blades etc.)
  - ✓ Baggy/inappropriate clothing (e.g. long sleeves in summer)
  - ✓ Frequent bandages
  - ✓ Fresh cuts/bruises
  - ✓ Old scars

Treatment and Interventions

- "Therapists consistently report self-injury **as the most distressing and traumatizing behavior** encountered in clinical practice."

- **Treatment of Self-Injury is a long-term investment**
  - ✓ Need to deal with the underlying issues before behaviors stop
  - ✓ Individuals often undermine therapy due to ambivalence about getting well
  - ✓ Difficult to let injuries heal (both physical and emotional)
  - ✓ Contract for safety (don't ask individual **not** to self-injure but to manage it)

Treatment and Interventions cont.

- **General Therapy**
  - ✓Working on self-esteem
  - ✓Helping people to find a voice
  - ✓Healing power of therapeutic relationship
  - ✓Empowerment (give client responsibility for treatment)
  - ✓Establish an environment where expression of emotion is safe
  - ✓Creation of a personal safe place

Treatment and Interventions cont.

- ✓Give the person the necessary space and time to heal
  - ✓Discuss their internal resistance and ambivalence toward therapy
  - ✓Manage the dissociation by engaging the senses (grounding)

Treatment and Interventions cont.

- ✓Develop their social support network
  - ✓Have them nurture a relationship with self (affirmations)
  - ✓Journaling
  - ✓If appropriate, encourage them to get a pet (unconditional love)
  - ✓Incorporate healthy spirituality (i.e. forgiveness, grace etc.)

What Can We Do to Help People Who Self-Harm?

- Pay attention to the young person's moods.
- While they may hide evidence of self-harm, noticing particularly irritable flashes, depression or when a young person is unusually withdrawn may be indicators of possible self-harm.

What Can We Do to Help People Who Self-Harm?

- Obviously, it's entirely possible that these emotions do not indicate self-harm, but they may be a warning flag if a person has a self-harm history.
- Don't ever ignore comments about self-harm.

What Can We Do to Help People Who Self-Harm?

- While it might be tempting to think that a person is being dramatic or overly sensitive, it is important to take any kind of suggestion of self-harm seriously.
- Be aware that emergency medical help may need to be sought!

What to Do If a Young Person Has Self-Harmed

- **If the self-harming is physically relatively minor (all self-harming is serious--superficial wounds), help bathe, clean and dress the wounds, and then make an appointment with the doctor.**

What to Do If a Young Person Has Self-Harmed

- Talk about the need to seek medical help with the youth, and explain why you want them to talk about their problems.
- Until the medical appointment, be attentive to changes in the sufferer's mood to ensure that they are stable and that the incident is not likely to repeat itself.

What to Do If a Young Person Has Self-Harmed

- If the wounds are deeper, bleeding or severe, such as burns, or if this is a repeat self-harming episode within a short space of time, it is important to seek emergency medical attention right away.
- If the person is unconscious, in an altered state of consciousness, or is bleeding profusely, seek emergency medical attention without delay.

Tips from other self-injurers

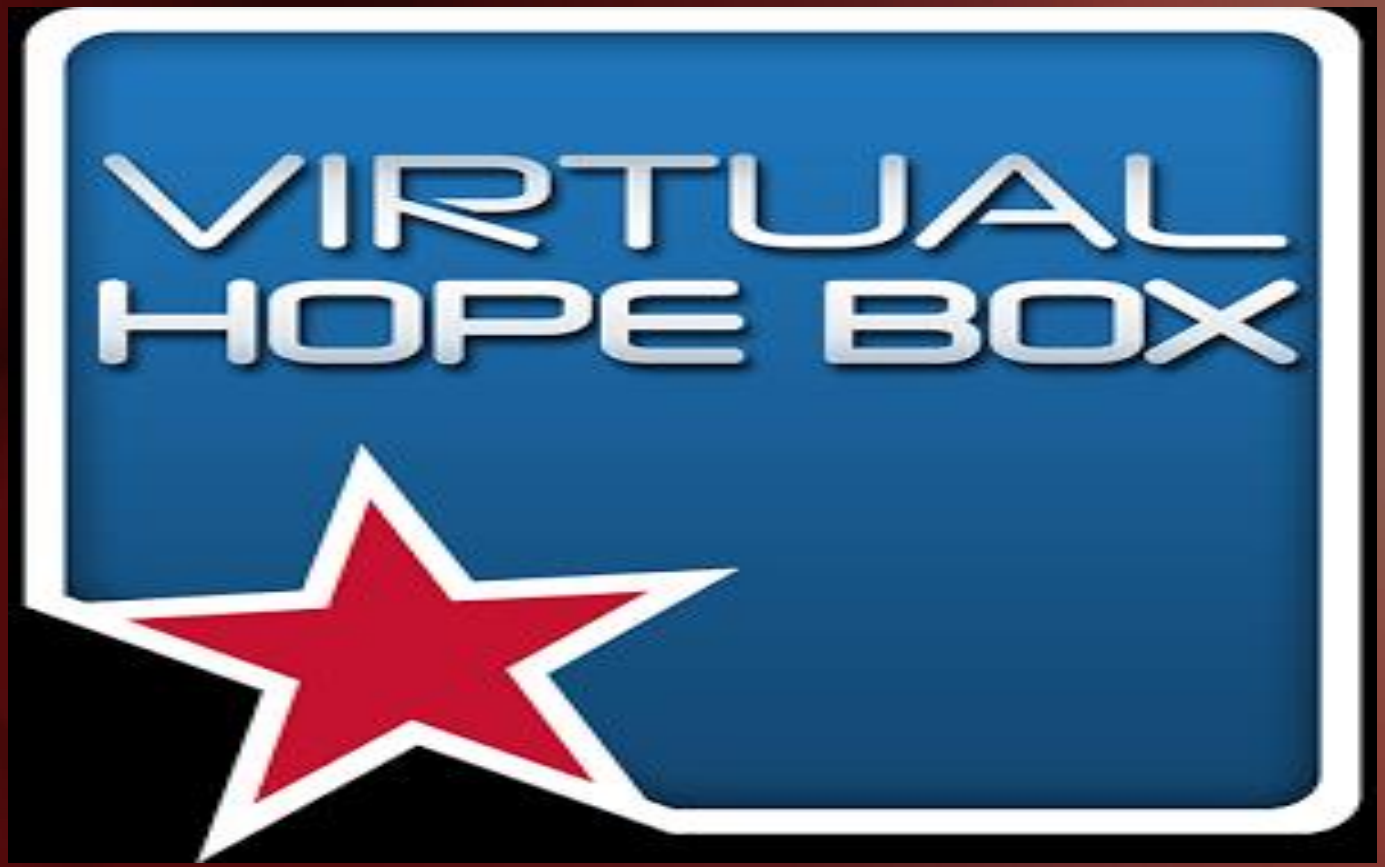
- Carry ‘safe stuff’ in pockets along with razor blades
- Keep your hands and brain occupied (puzzles, games etc.)
- Use a red felt tip pen to make slash marks on arm
- Use an ice cube over cutting area (mimics pain)
- Warm up red food coloring, drip on arm
- Put elastic bands on wrists, ‘snap’ when urge comes

More at http://www.palace.net/~llama/psych/fself.html

Tips from other self-injurers

- Get a haircut or dye hair
- Paint nails/bite nails (in moderation)
- Scribble with a red crayon/chalk on paper/sidewalk
- Rip up paper
- Engage senses (Rub liniment under nose, slap a tabletop hard, take a cold bath, bite into a hot pepper, stomp feet on the ground)
- Use henna dye on arms (can be picked off, leaves red mark)

Apps on the Phone


VIRTUAL
HOPE BOX


MY3

Others

- STOP, BREATHE & THINK APP
- Calm
- **Suicide Safe: The Suicide Prevention App for Health Care Providers**
  Free from SAMHSA
- **HELP Prevent Suicide**

Crisis Response Plans

Crisis Response Plans

- Crisis Response Plans need to
  - 1) assess access to lethal means
  - 2) emphasize temporal nature of adolescent suicidal experience
  - 3) build in reinforcement of managing emotions and thoughts with concreteness—use mindfulness & self-soothing strategies

Crisis Response Plans

- 4) acknowledge substance use if noted
- 5) be solution-focused
- Crisis Support Plans need to
  - 1) have a psychoeducational component
  - 2) be hopeful, and collaborative
  - 3) clearly identify the steps necessary to ensure safety

Living with Self-harm--Tips for Parents/Caretakers

- **Recognize the stress that can culminate in possible health issues**
  - **Have regular checkups**
- Coping with a young person's self-harm can put a strain on parents' relationships
  - Focus on investing quality time to share with each other
  - Parents will need to see how their work and finances may be affected and be able to develop a planned response.
-

Living with Self-harm--Tips for Parents/Caretakers

- Parent vulnerability to mental health issues such as anxiety, depression, and reliving past trauma/loss may be intensified.
  - Individual mental health therapy is recommended
-

Living with Self-harm--Tips for Parents/Caretakers

- Parent/child relationships can dissolve with anger, shame, etc.
  - Parent/child boundaries need to be reexamined
  - Parent/child experiences need to be shared
  - Agreements need to become transparent
  - Access to internet/social media openly discussed

Resources

- **Authors**
  - ✓ Favazza, A. R
  - ✓ Conterio, K.
  - ✓ Gratz, K.
  - ✓ Lader W.
  - ✓ Linehan, M.
  - ✓ Strong, M.
  - ✓ Whitlock, J.
  - ✓ Mulkenkamp
  - ✓**Lewis, S.**
  - ✓ **Muehlenkamp J.**
  - ✓**Klonsky, D**
  - ✓**Walsh B.**
- **Web**
  - ✓ American Self-Harm Information Clearinghouse: http://www.selfinjury.org/
  - ✓ Cornell University Research Program on SIB: http://www.crpsib.com/whatissi.asp
  - ✓ S.A.F.E. Alternatives: http://www.selfinjury.com/